Health and Community Services
Health Department

Medical Screening Questionnaire

SECTION 1	PERSON TO BE VACCINATED INFORMATION	
BIRTHDATE:	FIRST NAME:	LAST NAME:

SECTION 2 MEDICAL SCREENING QUESTIONNAIRE		
1. Is the person to be vaccinated currently ill or running a fever?	☐ Yes	☐ No
2. Has the person to be vaccinated received any vaccine within the past 30 days?	☐ Yes	☐ No
3. Has the person to be vaccinated ever had a serious reaction to a vaccine?	☐ Yes	☐ No
4. Does the person to be vaccinated have any allergies including but not limited to yeast, gelatin, or any medications?	☐ Yes	☐ No
5. Is the person to be vaccinated currently pregnant or breastfeeding?	☐ Yes	☐ No
6. Does the person to be vaccinated have any long term health conditions, including but not limited to low platelet counts or bleeding disorders?	☐ Yes	☐ No
7. Is the person to be vaccinated currently taking any medications including but not limited to aspirin?	☐ Yes	☐ No
8. Does the person to be vaccinated have asthma, or have they had a wheezing episode within the past 12 months?	☐ Yes	☐ No
9. Has the person to be vaccinated received COVID-19 vaccine ***before or during*** hematopoietic cell transplant (HCT), CAR-T-Cell therapies, or B-cell-depleting therapies?	☐ Yes	☐ No
10. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐ Yes	☐ No
11. Has the person to be vaccinated, or any of their immediate family members ever had convulsions, seizures, or epilepsy?	☐ Yes	☐ No
12. Does the person to be vaccinated have any health conditions or undergo any treatments that make them moderately or severely immunocompromised, including but not limited to being an organ transplant recipient, receiving chemo or radiation therapies, or high-dose corticosteroids?	☐ Yes	☐ No
13. Do you have close contact with anyone who has a severely weakened immune system?	☐ Yes	☐ No
14. Does the person to be vaccinated have a history of myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	☐ Yes	☐ No
15. Has the person to be vaccinated received any flu antiviral medication within the past 2-17 days?	☐ Yes	☐ No
16. Does the person to be vaccinated have a history of intussusception (an uncommon type of bowel obstruction) or any ongoing digestive system problems?	☐ Yes	☐ No
17. Has the person to be vaccinated received a blood transfusion, IG, or any other blood product within the past year?	☐ Yes	☐ No
18. Is the person to be vaccinated a current smoker?	☐ Yes	☐ No

CONSENT FOR SERVICES: I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities.

IN REGARDS TO COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:
I authorize any holder of medical information about me to release to Medicare and/or my commercial insurance or their intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

NOTICE OF PRIVACY PRACTICES: I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

By signing below, I hereby acknowledge that I have read and fully understand the statements on this form.

SIGNATURE of Client/Legal Guardian		Date	
PRINT NAME of Client/Legal Guardian			